MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136

07094

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city of town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or Institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ex. Delaware Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Thomas Bailey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 21, 1930

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
18	4	21		

9. Birthplace: North Hampton Co. Virginia
(Town, county, and state)
10. Usual occupation: Tailor Shop Helper
11. Industry or business:

FATHER
12. Name: Otha Bailey
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mariah Jenkins
15. Birthplace: Virginia

16. Informant: Mother-Mrs. Mariah Bailey
Address: Ex. Delaware St. Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 15 1948 (month) (day) (year)
Cemetery or crematory: Fairview Cem.
Location: Salisbury Md.
18. Funeral director: Booker M. West
Address: Salisbury, Md.

19. July 12 1948 (Date rec'd by registrar)
Albert R. Saunders Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1948 at 9:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1948 to July 12 1948 and that I last saw him alive on July 12 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	December 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: injured at work?

23. SIGNATURE: Reuben M. Swan, M. D. M. D. or other
Address: Henryton, Maryland Date signed: 7/12/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

07160

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VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs. 5 mos. 14 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 9 yrs. 5 mos. 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1720 Lemont Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: World #1 ✓

3.(a) FULL NAME

Arthur Hampton Beecher

3.(b) Social Security Number
217-18-1634

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Anna Aker Beecher

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 17, 1898

8. AGE: Years	Months	Days	If less than one day
50	2	11	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: James Beecher
13. Birthplace: Maryland

MOTHER
14. Maiden name: Henrietta Hampton
15. Birthplace: Maryland

16. Informant: Springfield State Hospital records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/31/48 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cemetery

Location: Baltimore, Md.

18. Funeral director: HENRY SANDER & SONS, INC.

Address: NORTH AVE. & BROADWAY

19. ..... 19..... (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19 48, at 7:34 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 19 48, to July 28 19 48 and that I last saw h... im... alive on July 28 19 48

Immediate cause of death	DURATION
Broncho-pneumonia	3 days
Old myocardial infarction	4 mos.
Due to:	
Due to:	
Other conditions: Psychosis with syphilitic meningo-encephalitis	1939

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D.
M. D. or other

Address: Springfield State Hospital Sykesville, Maryland Date signed: 7/29/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07101 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 7 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore -30-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 160 W. West Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THELMA CELESTINE BOLDEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married (Sep.)

6.(b) Name of husband or wife: Authur Bolden
6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): July 20, 1920

8. AGE:

Years	Months	Days	If less than one day
28	0	6	....hrs. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Solon Howard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Genevera Davis
15. Birthplace: Georgia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30 48 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cem't
Location: A B Co Md
18. Funeral director: Isaac L Brown Sr
Address: 1086 Montgomery St

19. July 26, 1948 (Date rec'd by registrar) Albert R. Swanborne Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1948 at 5:08P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19, 1948 to July 26, 1948 and that I last saw her alive on July 26, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben T. Johnson, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 7-26-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13b 8C

C7102

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years 2 months 9 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 760 Bradley Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Archie Lenard Bost

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 2, 1939

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
8	11	12		

9. Birthplace: Charlotte, N. Carolina (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Ledell Bost
13. Birthplace: Charlotte , N. Carolina

MOTHER
14. Maiden name: Janette Berry
15. Birthplace: Rock Hill, S.Carolina

16. Informant: Mother- Mrs. Janette Bost
Address: 760 Bradley Street, Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/17/48 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel Co. Md.
18. Funeral director: A. Halstead
Address: 918 Druid Hill Ave Balto.
19. July 14 1948 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: July 14 1948 at 3:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1946 to July 14 1948 and that I last saw h... im alive on July 14 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 1946
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben T. Swan, M. D. M. D. or other
Address: Henryton, Maryland Date signed: 7/14/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 07103

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 month, 9 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2642 Boone Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: VIVIAN LOUISE BROGDEN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
famale	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 31, 1932

8. AGE: Years	Months	Days	If less than one day
16	1	2	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER
12. Name: James Brogden
13. Birthplace: Virginia

MOTHER
14. Maiden name: Nannie Lee Royal
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6 48 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: A. A County Md.

16. Funeral director: Rayner Sanders

Address: 1412 E. Preston St.

19. 7/2 19 48 (Date rec'd by registrar) Albert R. Swandham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2, 1948, at 3.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1948 to July 2, 1948 and that I last saw her alive on July 2, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md Date signed 7/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 8-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 07104

Reg. Dist. No. 74

M

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Kate Berry Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Clarence E. Brown
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1868

8. AGE: Years 80 | Months - | Days 5 | If less than one day ... hrs. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Berry
13. Birthplace Md.

MOTHER 14. Maiden name Charlotte Heyworth
15. Birthplace Md.

16. Informant Mrs. Chas. N. Thompson
Address Sykesville Md.

17. Burial Date thereof July 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Springfield Cem.
Location Sykesville, Md.

18. Funeral director Harry Kerr
Address Sykesville, Md.

19. July 10 1948 Harry Kerr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1948 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945, to July 9, 1948 and that I last saw her alive on July 9, 1948

	DURATION
Immediate cause of death Uremia	
Due to Acute nephritis	
Due to	
Other conditions Cardio Vascular Disease	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other
Address Randallstown Date signed 7/15/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07105

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore -30-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 929 Leadenhall Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ROSETTA BROWN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 2, 1923

8. AGE: Years	Months	Days	If less than one day
24	10	24	hrs. min.

9. Birthplace: Pikesville, N. Carolina (Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business:

FATHER
12. Name: Johnnie Brown
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Bessie Mae Lane
15. Birthplace: North Carolina

16. Informant: Mother- B essie Mae Lane
Address: 929 Leadenhall Street, Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29 48 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: A P Co Md
18. Funeral director: Isaiah L Brandon
Address: 1080 Montgomery St

19. July 26, 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1948, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 1948 to July 26, 1948 and that I last saw her alive on July 26, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 8 1948
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben D Hyman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 7-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136

07106

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 2 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Vienna

(If outside city or town limits, write RURAL and give nearest town)

Street No. Nanticoke Rd. R.F.D.#3 Box 84

(If rural, give LOCATION)

(a) If veteran, name war: ✓

3. (a) FULL NAME: Arlee Camper

3. (b) Social Security Number: 144-09-1162

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 24, 1904

8. AGE:

Years	Months	Days	If less than one day
44	5	22	hrs. min.

9. Birthplace: Dorchester County, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER

12. Name: Fred Camper

13. Birthplace: Maryland

MOTHER

14. Maiden name: Julia Stanley

15. Birthplace: Maryland

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17, 1948 (month) (day) (year)

Cemetery or crematory: Nanticoke, Md.

Location: Worcester County

18. Funeral director: Cambridge, Md.

Address:

19. July 16 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: July 16 19 48 at 7:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 19 48 to July 16 19 48 and that I last saw him alive on July 16 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben T. Duncan, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 7/16/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

07107

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years, 4 months, 26 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 15 years, 4 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Amelia Dorsey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 1, 1875

8. AGE: Years	Months	Days	If less than one day
73	5	12	hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: house work
11. Industry or business

FATHER
12. Name: Frederick Zuschnitt
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine Herbech
15. Birthplace: Germany

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16 1948 (month) (day) (year)
Cemetery or crematory: Dorsey Cemetery
Location: Dorsey, Md.
18. Funeral director: C. Harry Wee
Address: Sykesville, Md.
19. July 14 1948 (Date received by registrar) C. Harry Wee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13, 1948, at 1.55 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942 to July 13, 1948 and that I last saw her alive on July 13, 1948

Immediate cause of death	DURATION
Coronary occlusion	15 minutes
Due to: generalized arteriosclerosis	about 16 years
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	about 15 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Irene Wehrmann, M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 7-13-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07108

Reg. Dist. No. 74

1. PLACE OF DEATH
County Carroll
City or town Henryton, Maryland
(If outside city of town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 641 W. Mulberry St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Roberta Savage Dorsey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	married

6.(b) Name of husband or wife Francis Dorsey
6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) December 16, 1916

8. AGE: Years	Months	Days	If less than one day
31	7	4	hrs. min.

9. Birthplace Drunhill, N. Carolina
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name Charles Savage
13. Birthplace N. Carolina

MOTHER
14. Maiden name Mimmie Goodness
15. Birthplace Virginia

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/23/48 (month) (day) (year)
Cemetery or crematory Mt Auburn
Location Buffalo Road Drunhill, S.C.

18. Funeral director Van A Jackson
Address 906 Penna Ave

19. July 20 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1948 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22, 1948 to July 20, 1948 and that I last saw her alive on July 20, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did Injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Herbert W. Rimes, M.D.
M. D. or other
Address Henryton, Maryland Date signed 7/20/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

07109

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Hook Road

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Walter Bradford Duvall

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Nina Miller

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov. 21 - 1861

8. AGE:

Years	Months	Days	If less than one day
86	8	2	... hrs. ... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Farmer - Ret.

11. Industry or business

FATHER

12. Name George W. Duvall

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Mary Cook

15. Birthplace Carroll Co. Md.

16. Informant Wilmer Duvall

Address Church ST. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25 - 1948 (month) (day) (year)

Cemetery or crematory Stone Chapel Cemetery

Location Warfields Bus, Md.

18. Funeral director H.B. Bankard & Son

Address Westminster, Md.

19. 7/24 1948 (Date rec'd by registrar) H. Kenneth Reindollar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1948 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Years ago 19... to July 23 1948 and that I last saw h... alive on July 16 1948

Immediate cause of death Generalized Arteriosclerosis — DURATION —

Due to ...

Due to ...

Other conditions ...

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work? —

23. SIGNATURE James T. Moore M. D.

M. D. or other

Address Westminster Md. Date signed 7/23/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

63e 07110

Reg. Dist. No. 76

M ✓

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster 4
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County CARROLL
City or town WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20 PENN. AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Cornelia Englar

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 1, 1871

8. AGE:

Years	Months	Days	If less than one day
76	11	14	..... hrs. ..... min.

9. Birthplace CARROLL Co. MD.
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace " "

MOTHER
14. Maiden name " "
15. Birthplace " "

16. Informant Maurice W. Englar
Address 34 W. Main St. Westminster Md

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof July 17 1948 (month) (day) (year)
Cemetery or crematory LUTHERAN CEMETERY
Location UNIONTOWN, MD.

18. Funeral director H Bankard & Son
Address Westminster, Md.

19. 7/16 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1948 at 7:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1948, to July 14 1948
and that I last saw h...e alive on July 13 1948

Immediate cause of death	DURATION
osteitis fibrosa cystica	about 5 yrs.
Due to Hyperparathyroidism	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Julius Chepko M. D.
M. D. or other
Address 88 W. Main Westminster Date signed 7/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07111

Reg. Dist. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural - Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Daniel Engle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	—

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JAN. 9, 1889

8. AGE:

Years	Months	Days	If less than one day
59	6	1	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-12-1948 (month) (day) (year)

Cemetery or crematory: Mt. Zion

Location: near Mt. Airy. Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. July 12 19 48 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 19 48 at 12:55 P.M. Prior to

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: James T. Marsh, Deputy Medical Examiner M. D. or other

Address: Baltimore Md. Date signed July 10, 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07112

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown 445 E. Lanvale St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Betty Leona Frank

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 4, 1910

8. AGE: Years	Months	Days	If less than one day
38	2	26	hrs. min.

9. Birthplace: Maryland

(Town, county, and state)

10. Usual occupation: Stenographer

11. Industry or business:

FATHER

12. Name: John Frank

13. Birthplace: Maryland

MOTHER

14. Maiden name: Bertha Rushmeyer

15. Birthplace: Maryland

16. Informant: Springfield State Hospital records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-2-48 (month) (day) (year)

Cemetery or crematory: Calvary Hill

Location: C. A. Co., Md.

18. Funeral director: Wm. Cook, Inc.

Address: 1217 St. Paul St.

19. July 31 1948 (Date rec'd by registrar) C. Henry Zile Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1948, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 1948, to July 30, 1948, and that I last saw her alive on July 30, 1948

	DURATION
Immediate cause of death: Pulmonary tuberculosis	4 mos.
Due to:	
Due to:	
Other conditions: Schizophrenia (Include pregnancy within 3 months of death)	11 yrs.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.

M. D. or other

Address: Springfield State Hospital Sykesville, Maryland Date signed: 7-31-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136

07113

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months5 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 414 N. Caroline
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Ida Gordon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Married

6.(b) Name of husband or wife: Phillip Gordon

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 15, 1917

8. AGE: Years	Months	Days	If less than one day
31	5	25	hrs. min.

9. Birthplace: Macanie, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Bernard Williams

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Minnie Thomas

15. Birthplace: Virginia

16. Informant: Deceased

Address

17. Shipped (Burial, cremation, or removal. Which?) Date thereof July 12, 1948 (month) (day) (year)

Cemetery or crematory

Location: La Crosse, Va

18. Funeral director: [redacted] & Elliott

Address: 112 [redacted] AVENUE

19. July 10, 1948 (Date rec'd by registrar) Albert R. Swanborn Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: July 10 19 48 at 12:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5 19 47, to July 10 19 48 and that I last saw her alive on July 10 19 48

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Jan. 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Swan, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 7/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 07114

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Mo. 22 DAys.
Hospital, Institution, or street address where death occurred:
Long View Nursing Home.
How long in hospital or institution? 7 Mo 22 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: HARRIET Graves.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: James Graves
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 19 1862

8. AGE: Years	Months	Days	If less than one day
86	6	7	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business:
FATHER 12. Name: Frederick Babold
13. Birthplace: Maryland
MOTHER 14. Maiden name: Ann Eliza ?
15. Birthplace: Maryland
16. Informant: Douglas Shepherd
Address: New Windsor, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/28/48 (month) (day) (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: Uniontown Road
18. Funeral director: D. O. Harbaugh & Sons
Address: Union Bridge Md New Windsor Md
July 28 1948 Mrs. W. P. S. Dennis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1948, at 6 45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4 1947, to July 26 1948
and that I last saw h[illegible] alive on July 25 1948

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to: Arteriosclerotic Cardio-Vascular Disease	?
Due to:	
Other conditions: Senility.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph E. Burk M.D.
M. D. or other
Address: Hampstead Md. Date signed 7-26-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 07115

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 4 months 8 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore -23
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 221 N. Bruce Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BEATRICE MILDRED GRAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Separated

6.(b) Name of husband or wife: William Gray
6.(c) If alive, give age: 45 years
7. Birth date of deceased (mo., day, yr.): January 1, 1905

8. AGE: Years	Months	Days	If less than one day
43	6	27	..... hrs. ..... min.

9. Birthplace: Greenville, N. Carolina (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:
FATHER 12. Name: James Barry
13. Birthplace: N. Carolina
MOTHER 14. Maiden name: Martha Downs
15. Birthplace: N. Carolina
16. Informant: Deceased
Address:
17. Shipped (Burial, cremation, or removal. Which?) Date thereof 7/29/48 (month) (day) (year)
Cemetery or crematory:
Location: Greenville, N. C.
18. Funeral director: Charles R Law
Address: 802 Madison Ave
19. July 28 19 48 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19 48 at 7:15 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 19 47 to July 28 19 48 and that I last saw her alive on July 28 19 48
Immediate cause of death: Pulmonary Tuberculosis — DURATION: May 194 4
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Kahn, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 7/28/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

928 — 07116

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 16 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3316 St Ambrose Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Grace Gross.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Parker Gross

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec 19th - 1881

8. AGE: Years: 66 | Months: 7 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: Balto Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER — 12. Name: William O'Brien

FATHER — 13. Birthplace: Balto.

MOTHER — 14. Maiden name: Emily Carey

MOTHER — 15. Birthplace: Balto Md.

16. Informant: Parker Gross. Address: 3316 St. Ambrose Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/2/48 (month) (day) (year)

Cemetery or crematory: Parkwood Cem.

Location: Parkville, Balto. Co. Md.

18. Funeral director: C. Vernon Lemmon.

Address: 4611 Park Heights Ave.

19. aug 2 1948 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29th 1948, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13th 1948, to July 29 1948; and that I last saw h— alive on July 29 1948

	DURATION
Immediate cause of death: Chronic Myocarditis	2 yrs
Due to: Mitral Regurgitation	2 yrs
Due to: Hypertension	—
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. J. Mastin M.D. M. D. or other

Address: Sykesville Md. Date signed: 7/29/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07117

94a

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, Institution, or street address where death occurred:
Penn. Cove.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 182 W. Main
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME George Ernest Hambruch

3.(b) Social Security Number 220-22-3755

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Wilhemenia Sauble
6.(c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr.) Nov. 11 - 1886

8. AGE:

Years	Months	Days	If less than one day
61	7	28	...hrs. ...min.

9. Birthplace Wheeling, W. Va.
(Town, county, and state)
10. Usual occupation Floor-Fireman
11. Industry or business

FATHER
12. Name not known
13. Birthplace " "

MOTHER
14. Maiden name " "
15. Birthplace " "

16. Informant Wilhemenia Hambruch
Address 182 W. Main. Westminster, Md.
17. Buried Date thereof July 10-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Meadowbranch Cem.
Location Jenny Town Rd. Westminster, Md.
18. Funeral director Wm. J. Dickinson
Address Balto. Md.
19. 7/8 1948 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7th 1948, at 4 35 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Disease of Coronary Arteries	Few minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE J. Billingslea, M.D.
Acting Deputy Medical Examiner
M. D. or other
Address Westminster, Md. Date signed 7-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07120

136

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or Institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2114 Pennsylvania Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Walter Harris

3.(b) Social Security Number: 217-07-9121

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 2, 1900

8. AGE: Years	Months	Days	If less than one day
48	2	22	hrs. min.

9. Birthplace: Chattanooga, Tennessee
(Town, county, and state)

10. Usual occupation: Bartender

11. Industry or business:

FATHER
12. Name: Walter Harris
13. Birthplace: (uknwon)

MOTHER
14. Maiden name: Carolinae Williams
15. Birthplace: (unknown)

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7.26.48 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City.

18. Funeral director: Geo. S. Folson
Address: 303 Preston St.

19. July 24 1948 (Date rec'd by registrar) Albert R. Swanblom Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1948 at 7 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1948 to July 24 1948 and that I last saw him alive on July 24 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	January 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: Reuben D. Brown, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 7/24/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

07118

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs 10 mos 12 d

Hospital, institution, or street address (where death occurred): Springfield State Hospital

How long in hospital or institution? 4 yr 10 mos 12 d

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Balto

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Charles E. Harvey.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Blanche Harvey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 2d 1886

8. AGE: Years	Months	Days	If less than one day
62	3	22	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer -

11. Industry or business:

FATHER — 12. Name: James E Harvey

13. Birthplace: Md

MOTHER — 14. Maiden name: Ann L Thayer

15. Birthplace: Md

16. Informant: Mrs Blanche Harvey

Address: 358 Coolidge Ave Balto

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 27-48 (month) (day) (year)

Cemetery or crematory: Salem cemetery

Location: Brookeville Md.

18. Funeral director: Raymond Bankert

Address: Laytonsville md.

19. July 26 1948 (Date rec'd by registrar) C. Henry Wee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1948, at 7-35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1943 to July 24 1948 and that I last saw ... alive on July 24 1948

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr
Due to: Arteriosclerosis	11 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W J Maston M D (M. D. or other)

Address: Sykesville Md. Date signed 7/24/48

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

07119

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since May 11, 1937

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? since May 11, 1937

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: xxxx

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. — — (If rural, give LOCATION)

2.(a) If veteran, name war — — —

3. (a) FULL NAME: STOKES, Herbert

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife — — —

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): (unknown) 1885

8. AGE: Years 63 | Months — | Days — | If less than one day ... hrs. ... min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: prize fighter

11. Industry or business — — —

FATHER 12. Name: Lawrence Herbert

13. Birthplace — — —

MOTHER 14. Maiden name: Tobitha Evans

15. Birthplace — —

16. Informant: Springfield State Hospital records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12, 1948 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: Asbury Heer

Address: Sykesville Md.

19. July 12 1948 (Date rec'd by registrar) Asbury Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1948, at 11.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947, to July 10 1948 and that I last saw him alive on July 10 1948

Immediate cause of death	DURATION
General Paralysis of the Insane	11 yrs
Due to: Syphilis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ——— Date of

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE: Martin Gross M.D.

Martin Gross, M. D. M. D. or other

Address: Sykesville, Maryland Date signed 7/10/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d ✓ 07121

Reg. Dist. No. 71

1. PLACE OF DEATH:
County: Carroll
City or town: Wakefield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Wakefield
(If outside city or town limits, write RURAL and give nearest town)
Street No.: New Windsor R.D.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Jacob Littleton Hess

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Madeline S. Hess
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): March 23, 1876

8. AGE:

Years	Months	Days	If less than one day
72	3	16	...hrs. ...min.

9. Birthplace: Towson, Md.
(Town, county, and state)
10. Usual occupation: Contractor (retired)
11. Industry or business

FATHER
12. Name: George E. Hess
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie E. Wisner
15. Birthplace: Maryland

16. Informant: Mrs. Jacob L. Hess
Address: Wakefield, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 7/12/48 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cemetery
Location: Towson, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. July 12 1948 (Date rec'd by registrar) Margaret R. England Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1948, at 12:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10, 1947, to July 9, 1948 and that I last saw h... alive on July 8, 1948

	DURATION
Immediate cause of death: Adenoma of kidneys -	6 wks.
Due to: Metastasis from Adenoma of kidney -	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Amputation of arm - Adenoma Renal Adenoma Date of op. Dec. 18th 47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Preston Boon (M.D.) M. D. or other
Address: Westminster - Md. Date signed 7/9/48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

07122 81

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Thomas R Hesson

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 - 1872

8. AGE: Years 75 | Months 7 | Days 7 | If less than one day hrs. min.

9. Birthplace Carroll County, Md
(Town, county, and state)

10. Usual occupation Butcher

11. Industry or business

FATHER 12. Name Milton Hesson

13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth Stem

15. Birthplace Maryland

16. Informant Mrs. Mahde E Martin

Address Union Bridge R. D. Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug 1 - 1948 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location Uniontown Road

18. Funeral director D D Hartzler & Sons

Address Union Bridge & New Windsor Md

19. July 30 1948 Leslie L Repp Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 - 1948 at 1:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1948 to July 30 1948 and that I last saw him alive on July 29 1948

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. N. Legg M. D. or other

Address Union Bridge Date signed 7-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83b

07123

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Sykesville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Liberty Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harry Wade Hughes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie Shipley Hughes

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Feb. 17 1883

8. AGE: Years: 65 Months: 4 Days: 25 If less than one day: hrs. min.

9. Birthplace: Freedom Carroll, Md.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: John Robert Hughes

13. Birthplace: Md.

MOTHER 14. Maiden name: Mary Elizabeth Sorrows

15. Birthplace: Md.

16. Informant: Mrs. Dorothy Manner

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 15, 1948 (month) (day) (year)

Cemetery or crematory: Freedom

Location: Sykesville, Md.

18. Funeral director: C. H. Deer

Address: Sykesville

19. July 14 1948 (Date rec'd by registrar) C. Harry Deer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1948 at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1948, to July 12, 1948 and that I last saw him alive on July 12, 1948

	DURATION
Immediate cause of death: Cerebral thrombosis	2 days
Due to: Arteriosclerosis & hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Md. Date signed: 7/14/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136 8c

07124

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryto, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Maryland Tubercilosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore -1-

(If outside city or town limits, write RURAL and give nearest town)

Street No. 437 W. Biddle Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LEROY HUMPHRIES

3.(b) Social Security Number: 214-05-3723

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 11, 1903

8. AGE:

Years	Months	Days	If less than one day
44	10	14	hrs. min.

9. Birthplace: Gaffney, S. Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Peter Humphries

13. Birthplace: Gaffney, S. Carolina

MOTHER — 14. Maiden name: Betty (unknown)

15. Birthplace: Gaffney, S. Carolina

16. Informant: Sister- Altie Thomas

Address: 1019 Madison Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/30/48 (month) (day) (year)

Cemetery or crematory: Arbutus Park

Location: Baltimore, Md.

18. Funeral director: Mrs. Samuel T. Hemsley

Address: 5-78 W. Biddle St.

19. July 25, 1948 (Date rec'd by registrar) Albert R. Sturmfels Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25, 1948, at 5:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22, 1948 to July 25, 1948 and that I last saw him alive on July 25, 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Unknown
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Swan, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 7-25-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13b 07125

Reg. Diat. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 18 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (30)

(If outside city or town limits, write RURAL and give nearest town)

Street No. 824 S. Sharp St.

(If rural, give LOCATION)

2.(a) If veteran, name war 1

3.(a) FULL NAME Percy Edwin Jackson

3.(b) Social Security Number 213-12-6312

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	married

6.(b) Name of husband or wife Edna Jackson

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) May 12, 1896

8. AGE: Years	Months	Days	If less than one day
52	2	8	....hrs. ....min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Levi Jackson

13. Birthplace Maryland

MOTHER 14. Maiden name Minnie Maddox

15. Birthplace Maryland

16. Informant Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25-48

Cemetery or crematory Mt. Auburn Cem. BALTIMORE NATIONAL CEMETERY

Location Balto. City

18. Funeral director James Andrews

Address 142 Woodall St

19. July 20, 1948 (Date rec'd by registrar) Albert R. Swandhaus Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1948, at 10:35A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2, 1948 to July 20, 1948 and that I last saw him alive on July 20, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Reuben D. Foman, M.D. M. D. or other

Address Henryton, Maryland Date signed 7/20/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07126

136

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 9 months 7 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Caroline
City or town Federalsburg,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Calvin S. Johnson

3.(b) Social Security Number: 220-07-0346

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 6, 1912

8. AGE: Years	Months	Days	If less than one day
36	2	7	..... hrs. ..... min.

9. Birthplace Federalsburg, Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Aron Johnson
13. Birthplace Maryland

MOTHER
14. Maiden name Ruth Philips
15. Birthplace Maryland

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/17/'48 (month) (day) (year)
Cemetery or crematory Federalsburg-
Location Federalsburg, Md
18. Funeral director E. J. Frampton
Address Federalsburg, Md.

19. July 13 19 48 (Date rec'd by registrar) Albert R. Greenhawk Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 19 48 at 11:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 1946 19 46 to July 13 19 48 and that I last saw him alive on July 13 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 7/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use continuation page is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

07127

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 27 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2427 S. Paca Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: William Johnson Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 13, 1920

8. AGE: Years	Months	Days	If less than one day
27	8	8	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: William Johnson Sr.
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lillian Simms
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24, 1948 (month) (day) (year)
Cemetery or crematory: Mt Auburn.
Location: Westport md.

18. Funeral director: Miss Katie R. Williams
Address: 322 N. Gilmor St.

19. July 21 19 48 (Date rec'd by registrar) Albert A. Swandlow Registrar
Deputy Local

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: July 21 19 48 at 5:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 19 48 to July 21 19 48 and that I last saw h... im alive on July 21 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Rowan M.D. M. D. or other
Address: Henryton, Maryland Date signed: 7/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136 07128

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Warwick
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Irene Virginia Lambert

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Married

6.(b) Name of husband or wife: Bradford Lambert

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 28, 1927

8. AGE: Years	Months	Days	If less than one day
20	11	12	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: William T. Price
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elnora Sewell
15. Birthplace: Maryland

16. Informant: Father- Mr. William T. Price

Address: Warwick, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 14 1948 (month) (day) (year)

Cemetery or crematory: Union Memorial Gardens

Location: Cecilton, Cecil Co., Md.

18. Funeral director: Joseph A. Turley

Address: 66 West Baner St Baltimore 23 Md

19. July 10 1948 (Date rec'd by registrar) Alice R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: July 10 1948 at 8:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1948 to July 10 1948 and that I last saw her alive on July 10 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Jan. 1948
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben W. Fraser, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 7/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

07124

136

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore - 1-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1115 Shields Place
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WILLIAM BEN MARKS

3.(b) Social Security Number: 220-01-3032

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (Sep.)

6.(b) Name of husband or wife: Dorothy Marks
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): July 31, 1912

8. AGE: Years	Months	Days	If less than one day
35	11	29	....hrs. ....min.

9. Birthplace: Miami, Florida (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Willie Henry Marks
13. Birthplace: Virginia

MOTHER
14. Maiden name: Rosa Brown
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial, cremation, or removal. Which?: Burial Date thereof: Monday, Aug. 2 1948 (month) (day) (year)
Cemetery or crematory: Mt Zion Cemetery
Location: Maryland
18. Funeral director: Mrs. Kate R. Williams
Address: 322 N. Schroeder St

19. July 30, 1948 (Date rec'd by registrar) Albert R. Swandtner Deputy, Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1948 at 7:35A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9, 1948 to July 30, 1948 and that I last saw him alive on July 30 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept., 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Eileen B. Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 7-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

07131

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs 5 mo 2 da

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 7 yrs 5 mo 2 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: John Raymond Miller

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M Married

6.(b) Name of husband or wife: Florence Miller

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1885 - July 10

8. AGE:

Years	Months	Days	If less than one day
63	0	10	hrs. min.

9. Birthplace: Md.

(Town, county, and state)

10. Usual occupation: Pharmacist

11. Industry or business: Retired.

FATHER 12. Name	John Miller
13. Birthplace	Md.
MOTHER 14. Maiden name	Florence Marshall
15. Birthplace	Md.

16. Informant: Rev. Raymond M. Miller Address: Funk's Grove, Ill.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/23/48 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem

Location: Baltimore

18. Funeral director: Philip Herwig Sons

Address: 2024 Orleans St.

19. July 22 19 48 a.w. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 19 48 at 11-30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 1st 19 41 to July 20 19 48

and that I last saw h[illegible] alive on July 20 19 48

	DURATION
Immediate cause of death: Coronary Thrombosis	1 hr.
Due to: Arterio Sclerosis	7 yrs
Other conditions: Hypertension	7 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. H. Hartman M.D. M. D. or other

Address: Sykesville Md. Date signed: 7/24/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07132

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

1. PLACE OF DEATH:
County Carroll
City or town Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural Westminster
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Martin Moffett

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Hester Eursery
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) about 1866

8. AGE: Years	Months	Days	If less than one day
About 82			hrs. min.

9. Birthplace Mitchell Co. N. C.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Field Moffitt
13. Birthplace N. C.

MOTHER
14. Maiden name Cynthia Garner
15. Birthplace N. C.

16. Informant Mrs Lous Butler
Address Pleasant Valley, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28-1948 (month) (day) (year)
Cemetery or crematory Simmons Cemetery
Location Milligan, Carter Co. Tenn.

18. Funeral director H. Bankard & Son
Address Westminster, Md.

19. 7/29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1948 at 1:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1947 to July 23 1948 and that I last saw him alive on July 22 1948

Immediate cause of death Cardiac Decompensation — DURATION 2 days

Due to arteriosclerosis (General)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other
Address Westminster Md. Date signed 7/24/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

07133

136

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryto
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 132 W. Cross St.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: William Montgomery

3.(b) Social Security Number: 252-18-9593

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	married

6.(b) Name of husband or wife: Mary Montgomery
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): October 12, 1908

8. AGE: Years	Months	Days	If less than one day
39	9	8	..... hrs. ..... min.

9. Birthplace: Sumter, S.Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: James Montgomery
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Parsons
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. ~~Burial~~ Removal (Burial, cremation, or removal. Which?) Date thereof July 23 1948 (month) (day) (year)
Cemetery or crematory
Location Summerton S.C
18. Funeral director: Sarah L Brown Sanitarium
Address 108 W Montgomery St
19. July 20 48 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 48 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25, 1948 to July 20 1948 and that I last saw him alive on July 20 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 7/20/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07130

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since March 22, 1923

Hospital, institution, or street address where death occurred: Springfield St. Hosp.

How long in hospital or institution? 25 years 3 months 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Swanton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Murphy, Martha

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife /

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) (not exactly known) ? 8 / 1868

8. AGE: Years: 80 | Months | Days | If less than one day: hrs. min.

9. Birthplace Garrett County, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Brother: Gilbert Murphy
Address Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6 1948 (month) (day) (year)
Cemetery or crematory Springfield Hospital Cem.
Location Sykesville, Md.

18. Funeral director C. Harry Heer
Address Sykesville Md.

19. July 5 19 48 C. Harry Heer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1948, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1923, to July 3, 1948
and that I last saw her alive on July 2, 1948

Immediate cause of death	DURATION
Generalized arteriosclerosis	18 yrs.
Due to: Myocardial degeneration	?
Due to:	
Other conditions: Mental Deficiency	Life

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D.
M. D. or other

Address Springfield State Hospital Date signed 7/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

07134

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural - Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months

Hospital, institution, or street address where death occurred:

Montevue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war NO

3.(a) FULL NAME Clarence Norris

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife Viola

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 19 1887

8. AGE: Years about 60 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore MD (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name William Norris

13. Birthplace Unknown

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Clarence Norris

Address 1755 Ormond St. Balto MD

17. Burial, cremation, or removal. Which?) Burial Date thereof 8/3/48 (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore MD

18. Funeral director Wilhelm & Son

Address 1219 E Fond St

19. (Date rec'd by registrar) Aug 3 1948 A. W. Hudnett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE James T. Marsh, Deputy Medical Examiner M. D. or other

Address Westminster Md Date signed 7/30/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1947
60
1887

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07135

932

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Pinkney Parrott

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary F. Parrott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 24 - 1878

8. AGE:

Years	Months	Days	If less than one day
69	7	9	..... hrs. ..... min.

9. Birthplace: Tappa, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: James Parrott

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Henrietta Mavis

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Oriolle Smith

Address: New Windsor, Md. R.D.

17. Burial, cremation, or removal. Which?: Burial Date thereof: 7/6/48 (month) (day) (year)

Cemetery or crematory: Spring Hill Cem.

Location: Easton, Maryland

18. Funeral director: H. H. Harbert & Sons

Address: Union Bridge & New Windsor, Md

19. July 3 1948 (Date rec'd by registrar) Emma S. Bunds Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1948 at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1948 to July 3 1948 and that I last saw h.im alive on July 2 1948

Immediate cause of death	DURATION
Cardiac Failure due	
to	
Due to: Hypertensive Cardio	
Vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Merrit E. Robertson M. D. or other

Address: New Windsor, Md. Date signed: July 3, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

07136

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural--Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Winfield, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3. (a). FULL NAME: HERBERT A. PICKETT

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Belva Pickett

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 3, 1890

8. AGE: Years	Months	Days	If less than one day
58	0	21	....hrs. ....min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: General Store

FATHER 12. Name: Charles S. Pickett

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Annie C. Skidmore

MOTHER 15. Birthplace: Maryland

16. Informant: Mrs. Belva Pickett

Address: Westminster, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 7-27-48 (month) (day) (year)

Cemetery ~~or crematory~~: Taylorsville

Location: Taylorsville, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfiel d, Md.

19. 7-26- 19 48 (Date rec'd by registrar) E. M. Formwalt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24th 19 48, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10th 19 48, to July 24 19 48

and that I last saw ... alive on ... 19 ...

Immediate cause of death: Aplastic Anemia — Chronic Interstitial Nephritis — DURATION: 6 mos, "

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. C. Bixler M. D. ~~or other~~

Address: New Windsor, Md. Date signed 7/25/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07137

136

Reg. Diat. No. 7X

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 13 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 617 Montgomery St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Grace Lillian Pierpont (GRACE LILLIAN PIERPONT)

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: William McKinley Pierpont

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 29, 1894

8. AGE: Years	Months	Days	If less than one day
53	10	28	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

MOTHER FATHER

12. Name: William Bersinger

13. Birthplace: Baltimore, Md.

14. Maiden name: Mary Wrenn

15. Birthplace: Maryland

16. Informant: Hospital records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/48 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Baltimore, Md.

18. Funeral director: HENRY SANDER & SONS, INC.

Address: NORTH AVE. & BROADWAY

19. 7/29 19 48 (Date rec'd by registrar) D. W. Redmond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27, 1948, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 14, 1947 to July 27, 1948 and that I last saw her alive on July 26, 1948

Immediate cause of death	DURATION
Pulmonary tuberculosis	2 yrs.
Due to: Involutional psychosis	9 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed 7/27/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 — 07138

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Linthicum, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? none resident

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County: York

City or town: Rural Glen Rock, R.D
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John E. Poole

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Henrietta Powell

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): June 12, 1877

8. AGE:

Years	Months	Days	If less than one day
71	1	12	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farmer

FATHER
12. Name: William Poole
13. Birthplace: Md

MOTHER
14. Maiden name: Jennie Hall
15. Birthplace: Md.

16. Informant: Mrs. John Poole
Address: Glen Rock Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28 1948 (month) (day) (year)

Cemetery or crematory: Western

Location: Balto., Md

18. Funeral director: H. Gelfuss

Address: Glen Rock Pa.

19. July 25th 1948 (Date rec'd by registrar) Mrs. W. P. J. Demmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1948 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 1948 to July 24 1948 and that I last saw him alive on July 19 1948

Immediate cause of death	DURATION
(a) Acute Heart Failure	
(b) Congestive Heart Failure	
Due to: (c) Hypertensive	
anteriorseptatic Heart Disease	4 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. H. Foard M. D.
M. D. or other

Address: Manchester, Md Date signed: July 24- 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

07139

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3Yrs. 9 Mo.s. 24 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-1 (If outside city or town limits, write RURAL and give nearest town)

Street No. 508 W. Hoffman Street (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Eugene Roberts

3.(b) Social Security Number: 213-01-2313

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 18, 1902

8. AGE: Years	Months	Days	If less than one day
45	11	12	hrs. min.

9. Birthplace: Oxford, N. Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Clem Roberts

13. Birthplace: N. Carolina

MOTHER — 14. Maiden name: Mary Liza Johnson

15. Birthplace: N. Carolina

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 3, 1948 (month) (day) (year)

Cemetery or crematory: Mt Auburn Cem.

Location: Baltimore City Md.

18. Funeral director: Charles H. Lang

Address: 802 Madison Ave

19. July 30, 1948 (Date rec'd by registrar) Albert Richardson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1948 at 10:20 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 1944 to July 30, 1948 and that I last saw him alive on July 30, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Brown M.D. M. D. or other

Address: Henryton, Maryland Date signed 7-30-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 BC 07140

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 808 E. Lexington Street

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME James Roberts

3.(b) Social Security Number 256-10-4687

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 6, 1919

8. AGE: Years	Months	Days	If less than one day
28	8	9	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John Roberts

13. Birthplace Unknown

MOTHER 14. Maiden name Lillian Unknown

15. Birthplace Unknown

16. Informant Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/9/48 (month) (day) (year)

Cemetery or crematory Baltimore city morgue

Location Baltimore Maryland

18. Funeral director Mrs Samuel T. Hemsley

Address 578 W. Biddle Street

19. July 5 1948 (Date rec'd by registrar) Albert R. Swanborne Local Deputy Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH July 5 1948 at 8:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1948 to July 5 1948 and that I last saw h... im alive on July 5 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben W. Thomas, M.D. M. D. or other

Address Henrton, Maryland Date signed 7/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 07141

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 27 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore 17 (If outside city or town limits, write RURAL and give nearest town)

Street No. 722 Pennsylvania Avenue (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George Sabb

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	Married

6.(b) Name of husband or wife: Alma Sabb

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): May 8, 1921

8. AGE: Years	Months	Days	If less than one day
27	2	21	..... hrs. ..... min.

9. Birthplace: Carlisle, S. Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Mose Sabb

13. Birthplace: (unknown)

MOTHER — 14. Maiden name: Sallie Briggs

15. Birthplace: Carlisle, S. Carolina

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/1/48 (month) (day) (year)

Cemetery or crematory:

Location: Sumpter, S.C.

18. Funeral director: Wm A Jackson

Address: 916 Penna Ave

19. July 29 1948 (Date rec'd by registrar) Albert A. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1948 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2, 1948 to July 29 1948 and that I last saw him alive on July 29 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1948
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Maryland Date signed: 7-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of age and birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Rc 136

07142

File No. G 116 JUL 27 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1757 Jefferson Street
(If rural, give LOCATION)

2.(a) If veteran, name war: N

3.(a) FULL NAME: Carrie Sanders

3.(b) Social Security Number: 214-20-3311

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 21, 1920 1923

8. AGE: Years	Months	Days	If less than one day
25 28	2	24	hrs. min.

9. Birthplace: Rock Hill, S. Carolina
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: James Sanders
13. Birthplace: S. Carolina

MOTHER
14. Maiden name: Susie Brown
15. Birthplace: S. Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 1948 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Brooklyn, Maryland

18. Funeral director: E. O. Watson

Address: 1000 Brandly Ave

19. July 15 1948 (Date rec'd by registrar) Albert R. Hemsley Deputy Local Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: July 15 1948 at 6:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1948 to July 15 1948 and that I last saw her alive on July 15 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Foman, M. D. (M. D. or other)

Address: Henryton, Maryland Date signed: 7/15/48

M MARGIN RESERVED FOR BINDING I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

85

07143

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs., 2 mos., 23 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 14 yrs., 2 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 418 S. Oldham Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: GEORGE SCHATZSCHNEIDER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	SINGLE

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 15, 1914

8. AGE: Years	Months	Days	If less than one day
34	3	5	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at home

FATHER — 12. Name: George Schatzschneider

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Florence Childs

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Florence Schatzschndier

Address: 418 South Oldham Street, Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24 1948 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Baltimore, Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. July 22 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 48 at 10.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Epilepsy	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: Thos. F. Ward Deputy Medical Examiner M. D. or other

Address: Westminster Md. Date signed 7/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07144

93d

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Lineboro, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Lineboro, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Emma Reinhart Shaffer

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widow.

6.(b) Name of husband or wife: Henry A. Shaffer

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 3, 1874

8. AGE:

Years	Months	Days	If less than one day
74	2	10	...hrs. ...min.

9. Birthplace: York Co. Pa.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER
12. Name: Samuel Reinhart
13. Birthplace: York Co. Pa.

MOTHER
14. Maiden name: Catherine Marble
15. Birthplace: York Co. Pa.

16. Informant: Ezra L. Shaffer
Address: Lineboro, Md.

17. Burial (Burial, cremation or removal. Which?) Date thereof 7/17/48 (month) (day) (year)

Cemetery or crematory: Fogarus Union Cemetery
Location: Lineboro Md

18. Funeral director: H. Gaither & Son
Address: Glen Rock Pa.

19. July 14 1948 (Date rec'd by registrar) Mrs. W. P. S Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1948; at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1948, to July 13 1948, and that I last saw ... alive on July 12 1948.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days.
Due to: Arteria-Sclerotic Cardio-vascular Disease	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Joseph E. Buck M.D.
M. D. or other

Address: Hanover Md. Date signed 7-13-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136 07145

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months 1 day

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 6 months 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4120 Park Heights Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

George Sherman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Mary C. Vogt

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 2 1873

8. AGE: Years 75 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual occupation: Gardener

11. Industry or business:

FATHER
12. Name: Peter Sherman
13. Birthplace: Balto Md.

MOTHER
14. Maiden name: Mary Rodt
15. Birthplace: Balto Md.

16. Informant: Springfield State Hospital records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30 1948 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Taylor Ave

18. Funeral director: Frank Della Vogue

Address: 322 E. High St.

19. July 29 1948 (Date rec'd by registrar) C. Haney Elkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19 48 at 3:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27 1948 to July 28 19 48 and that I last saw him alive on July 28 19 48

Immediate cause of death	DURATION
Pulmonary tuberculosis	2 yrs.
Due to Arteriosclerotic heart disease	3
Due to	
Other conditions Senile psychosis	8 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M.D. or other

Springfield State Hospital
Address: Sykesville, Maryland Date signed: 7/28/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of year of birth shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 116 AUG 2 - 1948

CERTIFICATE OF DEATH

13 b

07146

74

Reg. Diat. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5months., 4 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (1)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 656 George St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Careda Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	~~ma~~ Separated

6.(b) Name of husband or wife: William Smith
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): October 6, ~~1906~~ 1908

8. AGE:

Years	Months	Days	If less than one day
39	9	16	....hrs. ....min.

9. Birthplace: Howard Co. Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph Jones
13. Birthplace: Maryland

MOTHER
14. Maiden name: Cora Johnson
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-28-48 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel County, Md.
18. Funeral director: A. Halstead
Address: 918 Druid Hill Ave. Balto.

19. July 22 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 19 48 at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18 19 48 to July 22 19 48 and that I last saw her alive on July 22 19 48

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	January 6, 1948
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben A. Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 7/22/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

07147

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since March 13, 1948

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 3 months days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. ?
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Mary Elizabeth Sullivan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widow

6.(b) Name of husband or wife: Daniel Francis Sullivan
(deceased)

6.(c) If alive, give age: years

Date of birth of deceased (mo., day, yr.): 8-3-1863

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
84	11	11		

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER
12. Name: John Keating
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridget Dinnan
15. Birthplace: Ireland

16. Informant: Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17, 1948 (month) (day) (year)

Cemetery or crematory: St. Francis

Location: Abingdon Maryland

18. Funeral director: Howard F. McComas

Address: Abingdon Maryland

19. July 21 1948 (Date rec'd by registrar) Nancy Neer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1948, at 7:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1948 to July 14, 1948 and that I last saw her alive on July 13 1948

Immediate cause of death	DURATION
Generalized arteriosclerosis	?
Due to: Myocardial degeneration	?
Due to:	
Other conditions: Senile psychosis	16 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Springfield State Hospital Date signed: 7/14/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07148

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 5 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 mo., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4905 Crowson Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Sophia Adelaide Teawalt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Randolph T. Teawalt

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 7, 1857

8. AGE:

Years	Months	Days	If less than one day
90	7	21	..... hrs. ..... min.

9. Birthplace: Newcastle, Pa.
(Town, county, and state)

10. Usual occupation: Dressmaker

11. Industry or business:

FATHER
12. Name: Yingst
13. Birthplace: Germany

MOTHER
14. Maiden name: ?
15. Birthplace: Germany

16. Informant: Hospital records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 (month) (day) 1948 (year)

Cemetery or crematory: Monument Park Cem

Location: Taylor Ave

18. Funeral director: John C. Moran

Address: 3000 E Baltimore St

19. 7/30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28, 1948, at 8:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1948 to July 28, 1948 and that I last saw h.. alive on July 28 1948

	DURATION
Immediate cause of death: Pulmonary tuberculosis	1 mo.
Due to: Generalized arteriosclerosis	?
Arteriosclerotic heart disease	?
Due to:	
Other conditions: Senile psychosis	4-5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Springfield State Hospital Date signed 7/28/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

07149

83a

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Four days.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 8 yrs 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 181 W Pratt St. (If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Anna Kazmiak

3. (b) Social Security Number:

4. Sex: M. F. | 5. Color or race: W. | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years: 73 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: John Joseph

13. Birthplace: Ukraine Russia

MOTHER — 14. Maiden name: Anna Yarovnik

15. Birthplace: Russia

16. Informant: John J. Kazmiak

Address: 219 S Wolfe St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-30-48 (month) (day) (year)

Cemetery or crematory: Holy Cross

Location: Balto. md.

18. Funeral director: E. B. Wippert

Address: Eutaw & Lemmon Sts.

19. July 27 1948 (Date rec'd by registrar) C. Henry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27, 1948, at 11-05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1948 to July 27 1948

and that I last saw h[illegible] alive on July 27 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 hr.
Due to:	
Due to: Arterio Sclerosis	10 yrs
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed: 7/27/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 07150

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 9 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Leo Williams

3.(b) Social Security Number: 217-12-7030

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Carrie Bernice Williams

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): July 5, 1911

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
37	0	9		

9. Birthplace: Charles County, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Frank Williams

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Nellie Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Deceased

Address

17. Burial — Date thereof: 7 (month) 8 (day) 48 (year)
(Burial, cremation, or removal. Which?)

Cemetery or crematory: Mount Calvart

Location: Baltimore

18. Funeral director: Mrs L. D. Williams

Address: 322 4 D Schroeder St

19. July 14 19 48 — Albert R. Swarthout, Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: July 14 19 48 at 6:25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 19 48, to July 14 19 48 and that I last saw h im alive on July 14 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Neilan Hoffman M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 7/14/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07151

61

Reg. Dist. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Rural--Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: BERTHA C. WILLIAR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Jacob. O. Williar

deceased 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9, 1371

8. AGE: Years	Months	Days	If less than one day
77	3	21	hrs. min.

9. Birthplace: Frederick Co. Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: William Ecker

13. Birthplace: Maryland

MOTHER 14. Maiden name: Augustus Barnes

15. Birthplace: Maryland

16. Informant: Mrs. Harry Klein

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 8-2-48 (month) (day) (year)

Cemetery ~~or crematory~~: Locust Grove

Location: Woodville, Frederick Co. Md.

18. Funeral director: C. H. Waltz

Address: Winfield, Md.

19. July 31 1948 (Date rec'd by registrar) Thos. L. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1948, at 10 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1948 to July 30 1948 and that I last saw h.er alive on July 7th 1948

Immediate cause of death	DURATION
Uremic Poisoning	
Due to: Diabetes and Myocarditis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. M. Van Poole M. D. or other

Address: Mt Airy Md Date signed 7/31/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07152

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 19 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 409 S. Caroline Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Grace Wright

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 1, 1902

8. AGE: Years	Months	Days	If less than one day
45	11	12	hrs. min.

9. Birthplace: Norfolk, Virginia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Nathaniel Scott
13. Birthplace: Gloucester Co. Virginia

MOTHER
14. Maiden name: Mary Burrell
15. Birthplace: Gloucester Co. Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17-1948 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem.

Location: Brooklyn Md

18. Funeral director: Elroy O. Wilson

Address: 1000 Bidwell ave

19. July 13 1948 (Date rec'd by registrar) Albert R. Sandlow Registrar
Deputy Local

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: July 13 1948 at 8:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1948 to July 13 1948 and that I last saw h...er alive on July 13 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1 1948
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 7/13/48